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Christian Medical Commission World Council of Churches 150, route de Ferney 1211 Geneva 20 Switzerland

## IN SEARCH OF WHOLENESS...

# REACHING OUT TO ONE ANOTHER IN CARING AND HEALING

**In this Issue:**

*The cover photograph is of a detail from Michaelangelo's "Creation of Man" on the Sistine Chapel ceiling.*

While the principal function of CONTACT is to communicate the emphases and concerns of CMC to our constituency, direct reference to our work is usually confined to the notes at the end of each bulletin. Occasionally, however, as in CONTACT No. 39, which gave an account of the 1977 CMC annual meeting in Egham, UK, an entire issue is devoted to "CMC business".

Such is the theme of the present issue which highlights the CMC Study/Enquiry programme. This area of CMC work has, of course, determined the content of a number of previous issues of our bulletin as, for example, early issues on "Moral Issues and Health Care", "Secular and Christian Models of Health and Salvation", "Health Care and Justice" and, more recently, issues on "The Life and Witness of the Handicapped in the Christian Community" and "Relationships — the Third Dimension of Medicine".

The present issue traces the CMC Study/Enquiry from its origins — before the birth of the CMC itself — through its various stages of implementation and on to the fresh impetus gained from two recently held regional meetings. A description of the two meetings is linked with an account of our most recent Commission meeting whose site — the German Democratic Republic — was chosen on the basis of criteria arising out of the Study/Enquiry itself; much of the work at this meeting was also directly connected with the Study/Enquiry.

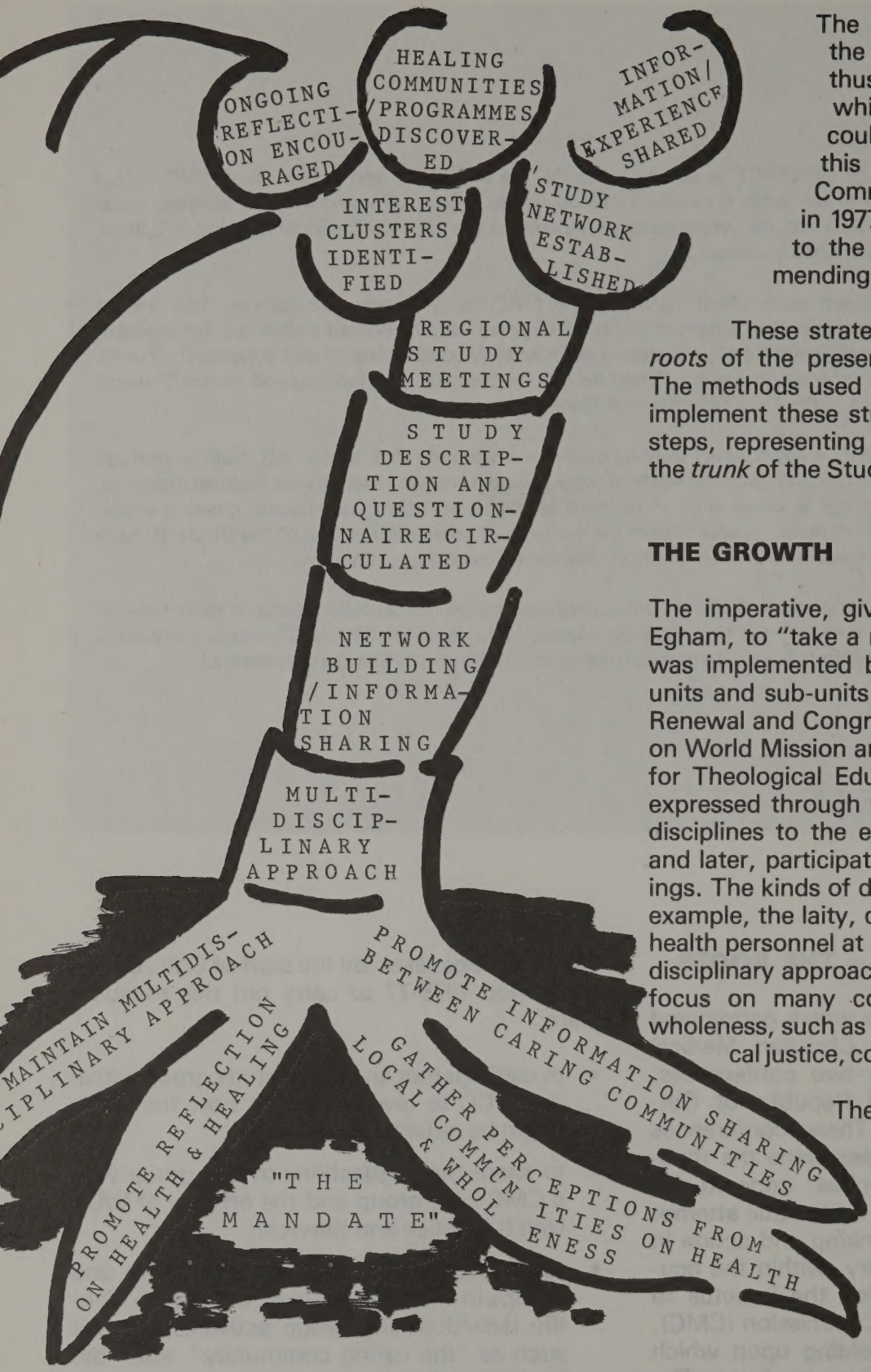
Complete reports of both the regional meetings are being prepared and will be available within a short time for those interested, as will the report of our Commission meeting. This issue of CONTACT simply provides a synopsis of these three meetings and situates them within the overall CMC Study/Enquiry programme.

## CMC STUDY/ENQUIRY — THE ROOTS

Important among the seeds which germinated in the foundation of the Christian Medical Commission in 1968 were two conferences, held in Tübingen, Federal Republic of Germany, in 1964 and 1967. These conferences underscored the need to reexamine the theological basis of the churches' concern for health. The need to make a systematic attempt to understand Christian thinking and action in the church's healing ministry, within the ecumenical movement, provided the impetus to create a Christian Medical Commission (CMC), and was part of the scaffolding upon which CMC's work in its early years was hung. The Central Committee of the World Council of Churches (WCC), after the 1975 Assembly in Nairobi, reaffirmed its concern by calling on CMC to "set up and develop means for sustained enquiry, description and reflection concerning connections between health, being human, the community, and the Kingdom of God."

The first steps taken by the staff of CMC during the period 1975-77 to carry out this mandate were:

- to call together an ad hoc study group within the WCC to give advice on how the study might be structured;
- to share the suggestions of this group with a CMC core group and the officers of WCC Unit II (Justice and Service);
- to initiate discussions with individuals and groups in various countries, in order to identify individual and group activities in areas such as "the caring community", and "the healing ministry";
- to circulate a questionnaire to Commission members;
- to assume responsibility for the publication of a book on traditional medicine by a Finnish theologian who had carried on an in-depth study of traditional medical practices in Tanzania.




The MANDATE to CMC from the WCC Central Committee thus constituted the *soil* in which the CMC Study/Enquiry could begin to grow. Based on this mandate, a meeting of the Commission at Egham, England, in 1977, gave a renewed impetus to the Study/Enquiry by recommending specific strategies to staff.

These strategies can be viewed as the *roots* of the present Study/Enquiry process. The methods used by CMC staff after 1977 to implement these strategies are depicted — in steps, representing a logistical sequence — as the *trunk* of the Study/Enquiry process.

## THE GROWTH

The imperative, given by the Commission at Egham, to "take a multidisciplinary approach" was implemented by consultation with other units and sub-units of the WCC, for example, Renewal and Congregational Life, Commission on World Mission and Evangelism, Programme for Theological Education and others. It was expressed through the contribution of various disciplines to the enquiry via correspondence and later, participation in regional study meetings. The kinds of disciplines enlisted were, for example, the laity, church hierarchy, peasants, health personnel at all levels. Finally, the multidisciplinary approach was expressed through a focus on many components of health and wholeness, such as social, economic and political justice, community participation, etc.

The three other strategies recommended by the Commission at Egham — promoting reflection, gathering perceptions from local communities, and promoting information sharing on caring communities — were implemented by various means. The activities in this implementation stage followed a certain logistical sequence, which began with letters to a wide range of individuals and organizations in a deliberate effort to contact a broad constituency, which could become a dynamic, growing *study network*. The sequence continued with the exchange of information with and within this infant network on articles, names, information on meetings, etc., concerned with study-related issues; with identification and documentation of "caring community" examples; with promotion of discussion between individuals and groups, and with keeping Commission members and other WCC units and sub-units informed of the progress of the study. A further step was the circulation of a description of the Study/Enquiry process to date to the study network in an effort to stimulate

thought on issues of health, healing and wholeness; this was followed by circulation of a questionnaire on the meaning of health and wholeness to participants in a Caribbean workshop on healing and among Nicaraguan health promoters. The answers from the questionnaires were summarized and analyzed and a number of "interest clusters" were identified.

On another front, the CMC participated in, and contributed to, a similar study being carried forward by a theological/health ministry group convened by the German Institute for Medical Mission in Tübingen. In June of 1978, the CMC invited Dr Paul Tournier, prophet of Interpersonal Relations as the "Third Dimension of Medicine", to speak at the Ecumenical Centre. Subsequently, his talk was published in the CMC bulletin CONTACT (No. 47, October 1978).

The final step in this first implementation stage has been the initiation of a cycle of regional and sub-regional study meetings; the first two are reported here.

## REGIONAL MEETINGS — "THE FLESH ON THE BONES"

With the holding of these two regional meetings in March 1979, one in Trinidad for the Caribbean and the other in Honduras for Central America, the CMC Study/Enquiry moved into a new phase. A process which, until then, had been tentative, diluted by geographical distances and lack of human contact, came abruptly alive through warm, vital, human interchange. Suddenly, the "bones" of the Study/Enquiry were covered in "flesh".

The objective of holding regional meetings was to test out the level of interest at "grassroots" regional level; to bring people of varying backgrounds but with common purpose out of their isolation — often total — and enable them to share information and experiences, engage in mutual reflection, identify their Christian role in contributing to health and wholeness of their communities, and to be stimulated and encouraged to continue both their reflection and their work.

While it is planned eventually to hold meetings in all the regions covered by the Study/Enquiry, the Caribbean and Central America were chosen initially. Participants in the meetings were selected from the study network of resource people, based on what had been learned of their interests, disciplines, programmes and commitment to a Christian responsibility for health and wholeness. The participant groups at both meetings were remarkable. This was due not only to the broad spectrum of interests and disciplines represented, but also to the fact that, in many cases, people with similar concerns, working in the same region, had no previous knowledge of each other's work, let alone existence. The bringing together of such a mix of people constituted a unique event in both regions and generated an atmosphere of wonderment, joy and excitement at both meetings.

The style of the meetings contributed to prolonging this mood, since it encouraged people to participate fully and contribute to the proceedings from their own experience. The agendas of both meetings had foci but were not prestructured. The participants themselves spontaneously identified the issues they wished to talk about. Fears that the meetings would be arenas for sterile colloquy dissipated when people met with others of like concerns and recognized the mutuality of their interests and needs. At a certain point in both meetings, participants split into broad interest groups to focus on selected issues. There was no attempt to formulate "final" conclusions, but both meetings arrived at a broad consensus of opinion.

The topics identified for discussion reflected the economic and political conditions in which the participants lived and the traditions out of which they grew. This allowed a unique regional flavour to emerge in each meeting. Areas covered included the search for definitions, such as the meaning of "wholeness" and its relation to social justice, or the contribution of people with disabilities to the wider community of those with no obvious handicaps; practical dilemmas, such as the difficulties and possibilities for exercising a healing ministry; and needs: to more closely observe and appreciate traditional healing and folk beliefs and to promote dialogue between medicine and theology.

### Caribbean Meeting: "Go and Tell..."

The goals of the regional meetings, outlined above, were expressed in a nutshell by the opening remarks of the General Secretary of the Caribbean Council of Churches at the meeting in Trinidad, who said:

*"This seminar is part of a world-wide study or enquiry concerning the church's understanding of mission in relation to health and healing and wholeness. Not only is the health of the individual preoccupying us, but the health of the family and of the nation."*

Since one of the objectives of the regional meetings was to test out, and give expression to, regional grassroots' interest in the Study/Enquiry, close cooperation with regional church bodies in the preparation and conduct of the meetings was essential. CMC's ecumenical co-partner in the region was the Caribbean Council of Churches (CCC) and St Andrew's Theological College in Trinidad. Port of Spain, Trinidad, was chosen as the site of the meeting for its convenience as the home base of the CCC and for its easy accessibility to all participants. The meeting was jointly chaired by CMC Moderator Dr Sylvia Talbot and Dr Martin Scheel, Vice-Moderator of CMC.

The twenty-five participants at the meeting were drawn from the wide range of interests and disciplines mentioned above, and the excitement, even gratitude, of the participants at being given this opportunity to meet and interact with others engaged with congregations in healing was an almost tangible element at the meeting.

Themes which provided a background to the discussion which followed were provided by three keynote papers. Professor William Watty of the Union Theological College of the West Indies, spoke on "Man and Healing: a Biblical and Theological View". Dr Arne Sovik, Project Director in the Studies Department of the Lutheran World Federation in Geneva traced "Our Beginnings" — the history of the CMC Study/Enquiry; and Mr John Steensma, Head of the Rehabilitation Department of the Jackson Memorial Hospital in Miami, Florida, talked about "Disabled People: Their Life in the Church".

The presentation on man and healing examined past attitudes to man as a total human being. The view taken by John Wesley in the mid-eighteenth century was an example quoted. It was pointed out that

*"... one of the basic conceptions of man we have in the Bible is one of totality. He is a psychosomatic being through and through, with all that entails... It is not that the body has a soul. Man is a living soul... Health is total. It is personal well-being. It is social harmony and justice. It is walking humbly with God."*

In the presentation on the beginnings of the CMC Study/Enquiry, trends in study and writings on health and healing from Europe, Asia, Africa, Latin America and North America were discussed and links to the present study were identified. Reference was made to some of the clearest messages coming out of the 1964 meeting at Tübingen:

*"Medical mission is not a tool for evangelism. It has a value in itself and, if it does not have that value, it is not worth doing."*

and

*"... the quality of the Christian health care ministry is not measured by the healing of a few sick people, those who can get to hospital. The Christian obligation, debt, if you want to use that word, is to the whole community...".*

The presentation on the disabled person's role in the church was a very personal perspective on this topic. John Steensma had lost both his hands at the age of seventeen. His personalizing of the theme, the graphic and clear nature of his statements and the participation of his wife, who works with disabled people, in the meeting, *illustrated* the positive contribution of disabled people to the wholeness of the congregation. Mr Steensma explored the many attitudes of people to the disabled: their gestures, looks, words, all of which display their biases and lack of realism in dealing with the handicapped and their inability to see the handicapped as "real or whole people". Mr Steensma made some suggestions: that we learn to know ourselves individually, and that in our attitudes to and behaviour with disabled people, we are empathetic and yet objective.

*"Don't be afraid to touch people. Be sensitive, be observant, consistently sensitive. Look at people... Be a listener... Be consistent... Be imaginative and be creative."*

He also raised some questions:

*"What are our ambitions... our goals... tolerances... prejudices... values, and are we going to impose these on others?"*

The twenty or so issues identified by the participants for discussion at the meeting fell into four major clusters. These were: **Congregation and Community**, where the focus was on the meaning of health and the identification of truly "basic" needs; church-state relations in health care; the economic aspects of health care as a challenge to the church; **Theology**, where topics such as the confessing church and forgiveness, Caribbean attitudes towards health and wholeness, indigenous

healing, healthy and unhealthy aspects of theology, charismatic renewal and dialogue between medical and theology students were discussed; the **Ministry of Disabled People to the Community and vice versa;** and **Practical Possibilities**, where the role of the church in family life, ministering to stress-related illness; the church in relation to the environment and the possibilities for establishing whole-person, church-based, multi-approach centres were explored.

One of the most inspiring spin-offs of the meeting was the bringing to light of several vigorous and imaginative church-related programmes, of which the Bethel Baptist Healing Center, directed by Dr Anthony Allen, was only one. The following description of the Center, put together from documentation provided and details gleaned from Dr Allen at the meeting, attempts to convey the spirit of the work being done there.

An elderly woman sits in a clinic waiting room holding a child of three on her lap. She is tired and the child is feverish and fretful. A group of nurses and doctors and other staff come in and invite the woman with the child and the rest of the patients to join them in the chapel. "We always start our clinic day with some prayers together," someone explains.

"What kind of a place is this?", the woman wonders as she limps after them. Her feet hurt, but the child is interested. After this novel beginning of a visit to the doctor's, she talks with an "intake counsellor" who, as it turns out, is a neighbour and calls her by her first name. She asks how long the child has had a fever, how his mother likes her new job in the city and how things are at home. Then it's the doctor's turn to talk to the little boy and his bemused grandmother. Nobody's in a hurry. A strange kind of clinic . . .

It is a fact, not fiction, though. It is called the Bethel Baptist Healing Center and it exists in Kingston, Jamaica. Its director is Dr Anthony Allen. When he introduced himself to other participants of the first CMC regional meeting in Trinidad in March 1979, he described himself as a "psychiatrist who has dabbled in theology". Dr Allen is also on the staff of the University Health Services of the University of the West Indies and is convenor of the Baptist Healing Ministries which now have five health centres in different parts of Jamaica. Bethel was the pioneer.

Its counselling, prayer and visitation services were started in 1974 and one year later, the medical clinic was opened, using the Sunday school building of the Bethel Baptist Church. The staff of ten physicians, ten nurses, seven trained counsellors, three medical technicians, four pharmacists and administrative, maintenance and Prayer Room staff volunteer their services on Mondays through Thursdays from 4:30 to 7:30 p.m. The doctors are general practitioners; persons requiring the attention of a specialist are referred. There is a consulting paediatrician. In addition to giving a medical diagnosis and writing prescriptions, Dr Allen explains, the doctors at Bethel "provide psychological counselling, spiritual counselling and prayer, as they are led by the Spirit of God. There is no attempt to force any patient to be involved in a religious discussion or in prayer."

The Center is not a free clinic. Fees are charged on a sliding scale. It is a "sharing plan" whereby those who can afford to pay more subsidize the cost of treating others who may not be able to pay at all. During its first three years, 1289 new patients were treated: an average of 429 a year. An average of twelve patients are seen each evening. Each patient has a twenty to thirty minute talk with the "intake counsellor" before seeing the doctor. The Center's staff believes that time is a vital ingredient of wholistic health care. People come from all over Kingston and outlying rural areas; they come from all walks of life too and the majority are not Baptists. There is a larger proportion of women than men among those who come to Bethel Center, and at least 42% of all the patients come because of non-medical problems with social, personal and financial worries predominating. The high rate of illnesses related to anxiety and hypertension indicate the need for a ministering to people's spiritual and psychological needs as well as physical.

People come to Bethel looking for a different kind of medical care. Describing the concept of healing practised here, Dr Allen speaks of the "atmosphere of fellowship and concern that seems to provide a crucial difference in the environment for the patient."

The church itself has "Healing Sundays" twice a year and prayer services every Sunday afternoon. Good Friday "Ashram" is another way in which members of the community come together to share their concerns.

When the Bethel Baptist Healing Ministry was begun, the Church Council said that "God is a God of medicines, miracles and men . . . the Lord has, from time to time, honoured our prayers with His healing activity. We feel that we ought to place greater emphasis on the healing of body and mind in our public ministry . . . healing of the whole man by means of counselling, medicine, faith and prayer . . . a total approach to the whole man."

Slightly over 40% of the patients who come to the Bethel Clinic do not return for further consultations. This may be because their complaint was a minor one or that they did not care for the Center's approach. It also might be, as most of the doctors and other personnel on the staff believe, that these people needed a friendly listening ear and reassurance.

Despite its strong Christian orientation, Bethel cannot be considered a charismatic healing centre. Yet, its staff recognizes a growing awareness of the need for retreats and house-based prayer fellowships and they have been influenced in their thinking by the charismatic renewal. "Our ambivalence and uncertainty about these beliefs and experience face us with a new challenge for openness," says a report from the Center which concludes that "it is our implicit belief in Divine Healing and our openness to the leading of the Holy Spirit that has sustained the discipline, faithfulness and effectiveness of our large staff which has been a witness to the Healing Christ."

The Trinidad meeting produced a consensus that

*"... health and wholeness imply the ability to grow, physically, mentally, socially and in our relationship with God; that social and economic injustices stand in the way of wholeness and that churches must recognize where they* ***prevent*** *wholeness as well as the opportunities they have to* ***foster*** *it within their communities."*

Among the outcomes of the meeting were the following concrete proposals:

- Plans to publish a popular booklet for Caribbean congregations on the healing ministry out of the formal report of this meeting, and to prepare a study guide from this booklet for use with congregations and communities.
- A resolution to continue the promotion of health and wholeness through conscientization projects, healing services (centres and visits) fact finding on needs and resources, study of spiritual healing, traditional healing, folk beliefs and the Bible.
- The injunction to *"Go and tell"* which symbolized the participants' strong wish to remain in touch with one another and to plan for future meetings within the region.

## Honduras Meeting: "One Expression of Love in Society is Justice"

CMC's ecumenical co-partner in Central America was the National Evangelical Committee for Development and Emergency (Comité Evangélico de Desarrollo y Emergencia Nacional — CEDEN) — a service organization supported by seventeen denominations, whose work includes health, housing, agriculture, staff and leadership development and relief activities. The staff of this Committee, based in Honduras with headquarters in Tegucigalpa, assumed full responsibility for all the local arrangements for the meeting, including selection of the site, transport, administration, etc. The beauty and complete isolation of the venue chosen (Omoa, near Puerto Cortés, on the Caribbean coast) contributed much to the spirit of fellowship and common purpose experienced by all the participants in this five-day consultation. Some fifty participants from seven Central and four South American countries and from North America attended the consultation, which was conducted in Spanish. The consultation was jointly moderated by CMC Commissioner Dr Gustavo Parajon and Rev. Emilio Castro, Director of the Commission on World Mission and Evangelism of the WCC in Geneva.

Keynote papers were presented by Rev. Emilio Castro, on "The Church and its Ministry of Health — a pastoral Vision"; Dr Ross Kinsler, Assistant Director of the Programme on Theological Education of the WCC, on "The theological Bases for the Involvement of the Church in Health Care"; and Mr Victor Vaca, of the Christian Medical Commission, on "The social and economic Context in which the Latin American Churches live."

The agenda of the consultation was determined by the participants, who split into groups to discuss the broadly defined interest areas identified, as was the case at the meeting in Trinidad. The Honduras consultation differed somewhat from the Trinidad one, however, in that a summary of conclusions and recommendations was given formal shape in a written document, produced on the final day of the meeting. It was hoped that this document would stimulate further reflection and action in favour of the total health in the region and, particularly, that it would contribute to the process of conscientization among the people of Central and South America.

The major subject areas identified for discussion in groups were the following:

**"The Gospel and health"**. Some concepts which emerged from a study of this topic were:

*"The greatest commandment (of the Bible) dictates that we love our neighbour with all of our being. One form of the expression of that love in society is justice... Transgression of the law... is sin and, socially, one can translate that into injustice which, at the same time, generates a state of illness, i.e., absence of physical, mental, social and spiritual well-being."*

and

*"Action without reflection or vice versa can not be considered a Christian act."*

The responsibility and means at the disposal of the churches to conscientize the people was stressed, as were certain desperate problems of the region needing particular highlighting in the conscientization process. The basic aim of such conscientization was seen to be:

*"...a critical examination of the current situation of oppression and dependence; concrete efforts in order to change this situation, the demand of universal human rights and (provision of) a new vision of people who will be able to create their own future."*

**"Discovery of challenges"** was the focus of a second group's study. There was consensus that individual Christians, congregations and churches should attempt to identify needs and problems in their communities and should make every possible effort to meet them. Such problems as the difficulties of people who are marginalized, handicapped or elderly; dealing with government and relations between churches, were given particular attention.

**"Resources and methodology of health of the total person"** was the third issue under consideration and problems of lack of information on, or inacccessibility of, human and material resources and excessive dependence on outside resources were discussed.

**"The prophetic responsibility of the church"** in facing up to repressive governments, lack of education and leadership, brain drain, exploitation, poverty, fatality, etc., in Central and Latin America was the fourth subject studied. A model of the Central/Latin American situation — an "analysis of reality" — was elaborated to assist the reflections of this group.

The theme of social justice was one which ran through all the deliberations at this consultation and formed the context for many of its final conclusions. The conclusions embraced suggestions on conscientization and emphasis on its importance for literacy, nutrition, community development, human rights and resource sharing; recommendations for specific health-improving activities for example:

*"That the churches now should get involved not only in... institutions and in the formal structures of health care, but in the education of the community for health (e.g., education of health promoters, midwives, clubs of housewives for health, curricular and extracurricular health education, etc.)"*

and

*"That we orient ourselves towards the health of the total person and not towards sickness."*

Also highlighted among the conclusions of the consultation was the recommendation for

*"...collaborating with governmental sectors (especially in health)... with other private groups that work in the community: other churches, cooperatives, unions, national and international organizations, popular movements, groups working in technology appropriate to local resources, but never in a paternalistic fashion, and so that the local community might be involved in the process."*

Throughout the consultation, and parallel to the theme of social justice, ran a commitment to the prophetic responsibility of the churches, expressed in the final document in the following terms:

*"We see that the churches should be the salt and light of the world, which implies working closely with, and relating to, the real world. (This implies that the churches should) preach a full Gospel that does not separate the spiritual and the physical in the person; preach the message of Christ which personifies all the problems of the neighbour and denounces injustice; recognize that silence in front of oppression speaks even louder than words; form a just structure of health, a policy of health, that incorporates all the governmental and non-governmental organizations; analyze reality in order to evaluate if the life of the church is consistent with its proclamation of the Gospel... use all their resources as an institution to speak honestly with the people, with the government and with international powers."*

As at the Trinidad meeting, learning of each other's work was a source of inspiration and mutual learning to the participants in the Honduras meeting. The following description of one of these programmes will help to convey the peculiarly Central/Latin American flavour and context of this consultation.

A small group of people are seated in a courtyard in Camagallito, a valley town high in the mountains of Guatemala in Huehuetenango State. Most of them are Indians. One is a man in his early thirties. He has walked all night from his village to get here. His name is Candelario and he is a Mam Indian. These mountains have been his people's home for two thousand years. He grows maize on his steep hillside farm and he has four children. He did not finish primary school, but he can read and write. Candelario is a health promoter and he has come to Camagallito to attend a refresher course. It begins, not with a lecture, but with a hymn.

Like the other fourteen "promotores" (health promoters) — four women and ten men — he lives with a number of problems: inequitable land distribution, lack of drinking water, schools and adequate housing, lack of technical assistance and/or appropriate technologies for agriculture, and starvation-level wages. In health terms, this syndrome of problems means malnutrition, parasitic disease and tuberculosis. What can be done?

"We have to educate by example," Candelario says. "For instance, in order to introduce the cultivation of a new crop, I try it out on my own plot of ground. To introduce the use of latrines in my village, I built my own and convinced my neighbours that it was a good idea, that there was less sickness."

"We are aiming at a rounded education for the children in our communities and for their parents," remarks the eldest health promoter.

"But it is difficult to educate others when I am not educated myself!", someone observes wistfully.

"The only way you can educate is to live with the people, share their customs and habits . . . I have had good results through loving people and reasoning with them," is the opinion of another promoter.

Who are these "promotores"? Like Candelario, most have been chosen by their own communities to take health training courses. These refresher courses are given at a centre operated by the Community of the Sisters of the Incarnate Word; the centre also houses a medical and dental clinic serving this rural area. The health training courses are offered by the Maryknoll Sisters of St Dominic as part of their educational programme for health promoters. The programme's headquarters are in Jacaltenango, and its present director is Sr Dr Maria Annel, a participant in CMC's Central American regional meeting in Honduras. One of the promoters who took the course — a local man whose education went no further than the first years of secondary school — is scheduled to take over from Sister Maria as director of the programme within a short time.*

Some of the promoters have completed as many as five of these four-day refresher courses. Their ages range between twenty-three and forty and the majority are of Mam origin, belonging to the Mam and Quiche Indian population. Their knowledge of the vernacular language spoken in this remote mountain region near the Mexican border allows them to communicate directly with the people with whom they work, which is difficult for urban doctors. Since there are very few state-run medical services available in this part of Guatemala, the health promoters are an intermediate solution to the complex problems of health care.

This refresher course has two objectives: it is an opportunity for the promoters to talk together about the problems and needs they have faced during their work, and to study the cause and treatment of allergies. There are two visitors today: Dr Lucia Terol, Director of the health programme of the Friendship Mission (Disciples of Christ) in Paraguay, and Mr Victor Vaca, a member of CMC's Geneva staff. As the visitors listen to the discussions and teaching, they are impressed by the sense of dedication and responsibility which the promoters obviously feel for their work. It has a genuine *mystique.* They do not seem to feel that the main value of attending these courses is to acquire knowledge, but rather, to discover what they can and should do with the practical knowledge they have accumulated.

There are no textbooks, just a series of simple booklets on various aspects of health care. The language and the line drawings used in them are simple and vivid; technical terms are used only when absolutely necessary. But it is important for the promoters to understand the cause of a disease and how to treat it, and the importance of preventive care, in order that they can explain this to the people.

"Sociodramas" are an effective teaching method used to help the promoters to diagnose an ailment. Promoters using this method in their communities depend upon a booklet guide which not only provides the necessary

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* A fuller account of this education programme is being prepared and will be available in due course. Those interested should direct their enquiries to CMC.

information on diseases and treatment, but also suggests questions which they can address to their audiences. Sister Maria is an accomplished actress and her audience cannot help but respond, either with empathy for her wracking cough as she simulates pneumonia, or her embarrassment as a poor peasant woman confronted with a supercilious city doctor. (Sister Maria's account of the Camagallito training programme at the Honduras meeting provoked some lively polemics and even inspired participants to enact a series of their own "socio-dramas".)

The "promotores" have their limitations of course. When they cannot handle a health problem, they refer the patient to the nearest clinic where specialized treatment is available. Sometimes, they accompany him or her to the clinic. Some doctors are not very happy with the "promotores", seeing them as threats to scientific medicine or even to their own economic interests. But more and more doctors have begun to recognize that the promoters do fulfil a very necessary function as colleagues in the effort to attain better health and social justice in Guatemala. The "promotores" can be seen as the cornerstone of primary health care and of all the work to raise the living conditions of the people of this deprived region.

## MEETING OF THE CMC 1-8 APRIL 1979 — "TOTAL SERVICE"

Since the inception of CMC, a "performance report" of its activities has been given by CMC staff to its Commission at full Commission meetings. Such a meeting was due in 1979 and one of the CMC Commission members, Rev. Ernst Petzold, Director of the Home Mission and Aid Service of the Evangelical Churches of the German Democratic Republic (GDR) (Innere Mission und Hilfswerk der Evangelischen Kirchen in der DDR), extended an invitation to CMC to hold its 1979 meeting at Bad Saarow in the GDR. His offer to host this meeting on behalf of the Home Mission was accepted with enthusiasm because of the chance thus afforded to demonstrate WCC solidarity with the churches of "East" Germany, and because of the special relevance of the Evangelical Churches' work to an important aspect of the CMC Study/Enquiry, i.e., the role of the handicapped in the life of the church and the community. In the GDR, the church has assumed a large portion of responsibility for the care of the handicapped and the aged, and the Commission was given the opportunity to visit several church-run institutions, among them the Samaritan Institutes in Fürstenwalde.

On these visits,

*"... the comprehensive, expert, loving and imaginative way in which handicapped people are served... both by medical and rehabilitative treatment made a deep impression on all."**

The integration into the life of the community of mentally and physically handicapped people is a cardinal point in the philosophy of the Evangelical Churches in their work with handicapped people. The belief that

*"... the care of the handicapped is not just a burden, but is the source of enrichment for the community and a joy... always out of proportion to the effort expended..."*

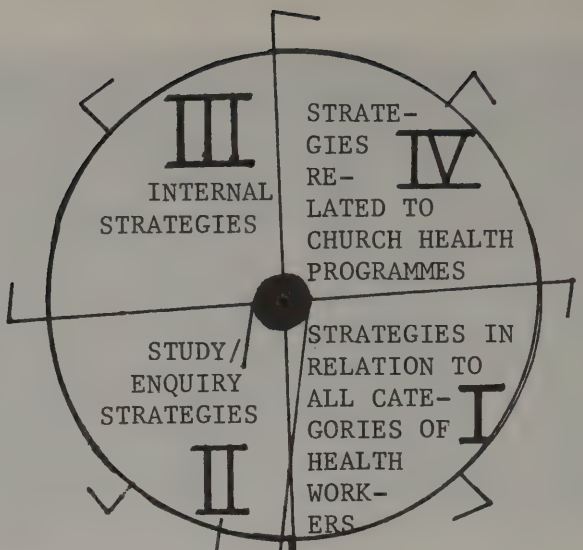
was evident in the diaconal services visited.

* This and the following quotations are exerpts from the report of this meeting written by one of the guest participants, Rev. Dr Paul Toaspern, Associate Director of the Home Mission. Rev. Toaspern's insight into the proceedings and underlying aims of the meeting were a measure of the extent to which he and the other guest participants from the Evangelical Churches in the GDR identified with the work of CMC.

## THE PATTERN OF CMC WORK

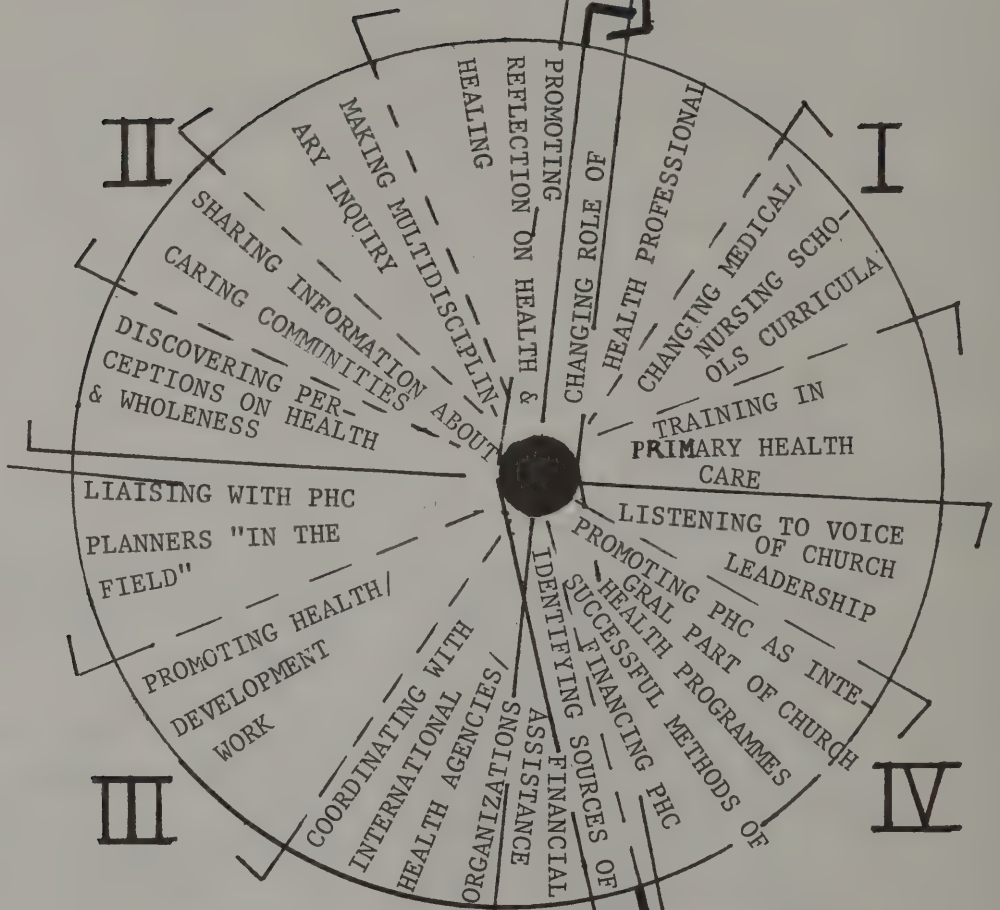
DIRECTIVES

(COMMISSION MEETING 1977)



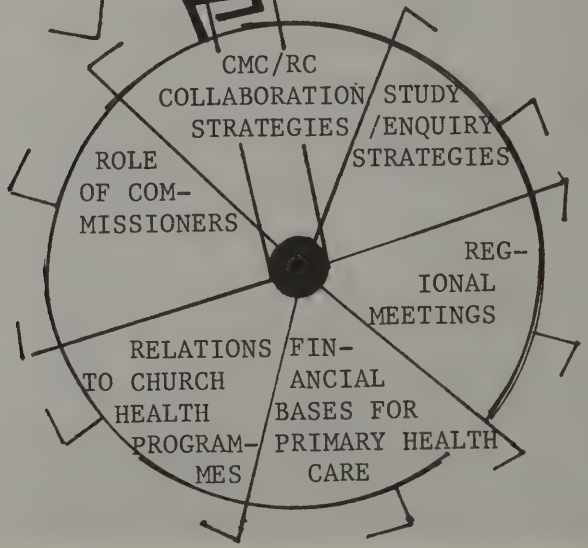

IMPLEMENTATION

(1977-1979)




NEW STRATEGIES

(COMMISSION MEETING 1979)



The CMC meeting at Bad Saarow was chaired by CMC Moderator Dr Sylvia Talbot. The Director, Ms Nita Barrow, presented a report on the progress of the CMC Study/Enquiry and on the implementation of the Commission's 1977 recommendations for work in other areas of CMC endeavour. Commissioners reacted by attempting to assess the degree to which their recommendations had been effectively carried out, and by reflection and decision on the directions to be taken by CMC staff in future work. (See diagram on The Pattern of CMC Work.) Considerable time was reserved for accounts from several commissioners on the progress of their own programmes in Egypt, Kenya, Nigeria, Zaïre, Japan, India, Sri Lanka, Indonesia, Nicaragua, Guyana, Bolivia and the USA. The reports from the GDR, given by Rev. Petzold and from Poland, by guest participant Rev. Ryszard Neumann from Czétochawa, also received close attention.

*"From these contributions... it was particularly evident how diverse and determined are the efforts being made by the Commission members and staff in the different countries; it was also clear, however, that many tasks are inevitably still uncompleted and that some (such) operation models can only point to possible... solutions to problems."*

The deliberations of the Commission over five days yielded a number of concrete recommendations for the next steps in CMC work. The recommendations covered such areas as finance, future collaboration with the Roman Catholic Church, the timing of the next Commission meeting, further regional Study/Enquiry meetings, the Study/Enquiry programme as a whole, the role of commissioners, the financial bases for health care programmes, fee-for-service health care and relations to church health programmes.

The staff and commissioners who participated in the regional meetings made every effort to describe the events at these meetings to the whole Commission in such a way as would convey their spirit of excitement, fellowship, mutual discovery and regional flavour. Note was made of the achievements of these meetings in terms of identifying key regional concerns and formulating resolutions for future work and cooperation in the regions. The Study/Enquiry focus of this Commission meeting thus served to remind all that

*"... the Christian Medical Commission is also concerned with the theological and medical aspects of such fundamental questions as: what do we really mean by 'health'? What does 'wholeness' mean for service which is based on the Gospel? To what extent can the church, a congregation, promote wholeness in its own individual members as well as in the community as such? What is meant by the 'church's healing ministry'?"*

The Commission was also reminded, in words it had itself once formulated, that

*"'A sick person is not just a suffering body, a deranged mind, or a wounded soul, but a whole person. In other words, purely technical and medical skills are not enough in themselves to meet the needs of the whole person.' ... that disturbed relationships contribute largely to physical and psychological illness; (that) the reality of faith healing, the power of prayer... the lessons to be learned from the experiences of charismatic renewal, prayer groups and... healing fellowships (which) are springing up in many parts of the world, even in the more traditional churches (all deserve serious study and attention)."*

*"A the Bad Saarow meeting, it was also clear, especially in the reports from developing countries, that wholeness is connected with social conditions and social structures, which, in many countries, bear the manifest marks of injustice and the violation of the basic human rights of certain groups in society. On this, the Commission's study programme declares: 'Basic medical care, which the Christian Medical Commission has tirelessly advocated ever since its inception, is one means of demolishing the unjust structures in medical care. We are referring here not merely to the unequal distribution of such medical care as between town and country and the overemphasis on remedial and institutional services, but also to the need to assign a far greater measure of self-reliance and participation to the people directly concerned, and for medical care as a whole to become the concern of the community as a whole.'*

*The reports presented at the Commission meeting provided encouraging confirmation of the degree to which the Commission members themselves are trying to advocate the Commission's principles. This can be seen in pioneering experiments, especially in rural areas in the developing countries, and in the promotion of every possible form of cooperation in the regions, with the further aim of influencing the general health services and legislation of individual countries. In this connection, enhanced importance attaches to the regional conferences to which not only practioners engaged in the church's healing ministry are invited, but also other interested people in the regions."*

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The three meetings just described here carried forward a pattern of work which has emerged as the style of relations between the CMC staff and its commissioners. This work pattern is

cyclical, with the Commission meeting providing directives → implementation → assessment/reflection → new strategies. It was essential at this midpoint in our Study/Enquiry programme that the pattern be imposed in reviewing the programme.

The three meetings have shown that, despite a long history of a healing ministry, the church has not always been, and is not always today, responsive to the needs of the people. It would perhaps be appropriate here to paraphrase some words from a report of the Ecumenical Workshop on "The Church of the Poor" (September 1978), and to substitute "the churches' medical work" for "the churches", since what is said about the latter applies equally to the former. Thus,

*"The churches' (medical work), having shown in the last centuries of (its) history that (it has) not been, and still (is) not, very close to the people ... should give the attention they deserve to the many and varied developments going on in the (health care) of the poor... This does not mean that all experiences at the grassroots level need to be institutionalized. The essential thing is for them to be seen as expressions of the pilgrimage of the people of God through history, always marching forward, looking to the future... and not remaining captive to the past and its traditions."*

Today, church-related health care programmes which are close to the poor and which attempt to make health care for all a reality are relatively few and far between, as are church-related healing ministry initiatives aimed at bringing about the health of the whole person. Not only are such programmes and initiatives rare; they are also as yet by no means universally accepted by, or acceptable to, the churches. CMC, therefore, continues to make it its mission to find, make known and, if possible, assist such programmes and initiatives, wherever they are, in the spirit of justice, service and wholeness.

## MEMBERS OF THE CHRISTIAN MEDICAL COMMISSION

| | Country of Origin | Church Affiliation |
|---|---|---|
| Mabelle AROLE, MD<br>Co-Director of Comprehensive Rural Health Programme, Jamkhed, Maharashtra State, India. | India | Church of North India |
| Marie B. ASSAAD<br>Senior Research Assistant, Social Research Center, American University, Cairo. | Egypt | Coptic Orthodox Church |
| Rev. Michael BENCKERT<br>Press and Public Relations' Officer, Evangelical Church of Bremen, Federal Republic of Germany. | Federal Republic of Germany | Evangelical Church in Germany |
| John H. BRYANT, MD<br>Director, Office of International Health, Department of Health, Education and Welfare, US Government, Rockville, Maryland. Formerly, Director, School of Public Health, Columbia University, New York. | USA | United Presbyterian Church |
| William H. FOEGE, MD<br>Director, Center for Disease Control, US Department of Health, Education and Welfare, US Government, Atlanta; specializing in smallpox eradication and measles control. Vast experience in West Africa and Asia. | USA | Lutheran Church—Missouri Synod |
| Colin E. FORBES, MD<br>Paediatrician in Nairobi. Formerly, Associate Professor of Community Health, Faculty of Medicine, University of Nairobi, Kenya. | Jamaica/Canada | Anglican |

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| Noboru IWAMURA, MD<br>Consultant in Community Health to the United Mission to Nepal and the Japan Overseas Christian Medical Cooperative Service (JOCS), Tokyo. | Japan | Mukyokai |
| Emil A.J. JEEVARATNAM, MD<br>Medical officer in charge of hospital in Sri Lanka. Member of WCC Central Committee. | Sri Lanka | Methodist |
| Dr Una KROLL<br>General practitioner and worker-deaconess of the Church of England. Special interests in psychosexual counselling, child development, relations between the sexes, interdisciplinary cooperation and patient participation in therapy. | UK | Church of England |
| Herman J. MIDDELKOOP, MD<br>Medical Secretary, Board of Mission of the Netherlands Reformed Church, Oegstgeest. Former medical missionary in Indonesia. | Netherlands | Durch Reformed Church |
| Rev. John A. MURDOCK<br>Associate General Secretary, Health and Welfare Ministries Division, United Methodist Church, New York. Trained in ministry and sociology; has served as pastor, teacher, consultant and administrator, with special focus on the needs of the poor, the sick, children, and the aged. | USA | United Methodist Church |
| Citoyen NLABA-NSONA<br>Director of Medical Services and Associate General Secretary of the Diaconia, Church of Christ in Zaïre. Previous experience in nursing, teaching and administration. | Zaïre | Eglise du Christ au Zaïre |
| Rt Rev. Jonathan A. ONYEMELUKWE<br>Bishop on the Niger. Many years of parish work in UK, Canada and Nigeria; Union Theological College Tutor and later Principal of a Union College. | Nigeria | Anglican |
| Gustavo A. PARAJON, MD<br>Director, Evangelical Committee for Development Aid (CEPAD), Managua, Nicaragua. Consultative services in community health in other Central American countries. | Nicaragua | First Baptist Church of Managua |
| Rev. Ernst PETZOLD<br>In charge of diaconal work in the German Democratic Republic (GDR); Director for the entire GDR of the Innere Mission. | German Democratic Republic | Evangelical Lutheran Church in Saxony |
| Martin SCHEEL, MD — Vice-Moderator<br>Director, German Institute for Medical Mission, Tübingen, Federal Republic of Germany. Previously, medical missionary in India. | Federal Republic of Germany | Evangelical Church in Germany |
| Peter J.H. STRANG, MD<br>General practitioner in Gore, New Zealand. Previously, medical missionary in Iruna, Papua New Guinea (PNG), and Liaison Officer between the Churches' Medical Council and the Department of Public Health of the PNG Government. | New Zealand | Presbyterian Church |
| Bert A. SUPIT, MD<br>Head of Regional Directorate of Health Care, North Sulawesi Province Department of Health: and Vice-Chairman of the Medical Commission, Synod Minahasa Evangelical Church; Director, Bethesda Hospital, Tomohon. Previously, Government Rural (District) Health Officer. | Indonesia | Minahasa Evangelical Christian Church |

| | | |
|---|---|---|
| Sylvia TALBOT, EdD — Moderator<br>Episcopal Supervisor of the African Methodist Episcopal Church for leadership development throughout the Caribbean with emphasis on women and youth. Former Minister of Health of Guyana. | Guyana/USA | African Methodist Episcopal Church |
| Eunice ZAMBRANA Villarroel<br>Nurse-technician on health planning; presently in Health Planning Office, Government Ministry of Health. Previously, Executive Secretary, Medical Committee, Methodist Church in Bolivia. | Bolivia | Methodist Church in Bolivia |

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